NRH Regional Rehab

Patient Name:
DOB:
MR#:

Outpatient Health History (Confidential)

Emergency Contact:________________________________ **Relationship:**_________________ **Phone #:**_______________
Reason for Referral:____
Person Completing form: ___________________________ ☐ **Patient** ☐ **Other** _________________ **Date:**____________

MEDICAL HISTORY (PLEASE CHECK ALL MEDICAL DIAGNOSIS AND CONDITIONS THAT APPLY)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chemical Dependency
- ☐ Communicable Disease:
  - ☐ HIV+ ☐ HPV ☐ MRSA
  - ☐ VRE ☐ E Coli ☐ Scabies
  - ☐ Herpes Zoster ☐_______________
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Irregular or Rapid Heart Beat
- ☐ Joint Replacement / Metal Implant
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Motor Vehicle Injury
- ☐ Pacemaker
- ☐ Current Pregnancy
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Work Injury

☐ ***Other medical condition if not listed above***: ____

PAIN: Do you currently have pain or have you had pain in the recent past? ☐ YES ☐ NO *If Yes, complete Pain Questionnaire*

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Productive cough	Yes ☐	No ☐	Trouble breathing	Yes ☐	No ☐	Constipation	Yes ☐	No ☐
Fever / Chill	Yes ☐	No ☐	Joint pain	Yes ☐	No ☐	Bloody Stools	Yes ☐	No ☐
Coughing up blood	Yes ☐	No ☐	Joint stiffness	Yes ☐	No ☐	Difficulty or pain with urination	Yes ☐	No ☐
Night sweats	Yes ☐	No ☐	Rashes or skin changes	Yes ☐	No ☐	Incontinent bladder	Yes ☐	No ☐
Nausea / Vomiting	Yes ☐	No ☐	Visual changes	Yes ☐	No ☐	Incontinent bowel	Yes ☐	No ☐
Chest pain	Yes ☐	No ☐	Hearing changes	Yes ☐	No ☐	Other:____________________	Yes ☐	No ☐

NUTRITION: Are you concerned about your Nutrition? ☐ Yes ☐ No Have you had an unexplained weight loss? ☐ Yes ☐ No
Have you had an unexplained weight gain? ☐ Yes ☐ No Specify loss or gain: ______lbs

FALLS: Are you concerned about falling? ☐ Yes ☐ No Have you fallen in the last year? ☐ Yes ☐ No If yes, Date : _______
Have you fallen more than 2 times? ☐ Yes ☐ No Has any fall resulted in injury? ☐ Yes ☐ No Specify:_______________

IMMUNIZATION: **(For Pediatric Patients Only) Check (✓) if you have been immunized for the following:**
DPT (Diphtheria, Pertussis, Tetanus) ☐ Yes ☐ No Chickenpox (Varicella) ☐ Yes ☐ No ☐ MMR (Measles, Mumps, Rubella) ☐ Yes ☐ No

SURGERIES / HOSPITAL PROCEDURES

____
____

ALLERGIES / DRUG INTERACTIONS

Many rehab clinic products contain Latex. ***Do you have any allergy to Latex?*** ☐ Yes ☐ No
____

CURRENT MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBAL PREPARATIONS)

Medication Name	Dose	Frequency	Reason

The information on this form will be reviewed and discussed with the patient, and the information will be incorporated into the treatment goals and plan of care established in collaboration with the patient. Refer to individual service area evaluations and care plans.

HËG€FG

Patient Name:
DOB:
MR#:

NRH Regional Rehab

Initial Evaluation Pain Questionnaire/Assessment

❶ Please rate your pain by circling the number that describes your pain at **its worst in the last three (3) days:**

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst pain

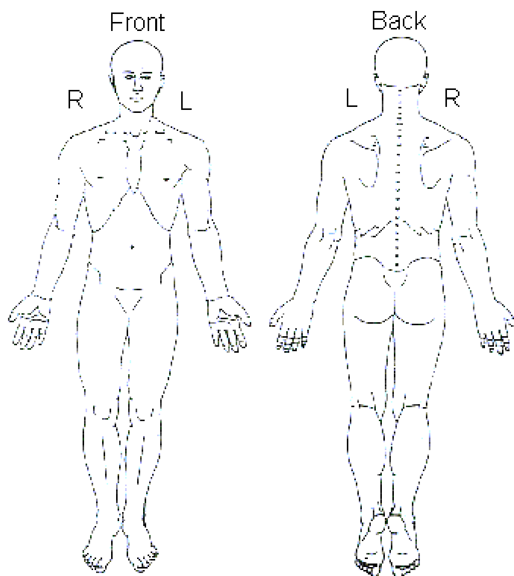
❷ Please rate your pain by circling the number that describes your pain at **its least in the last three (3) days:**

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst pain

❸ Please rate your pain by circling the number that tells how much **pain you have right now:**

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst pain

❹ On the diagram below, shade in the areas on the body where you feel pain. Put an X on the area that hurts most:



❺ Place a check mark (✓) in the Yes box if the word describes your pain and if the symptom is present, indicate with a check mark (✓) if it is constant or occasional.

Aching	☐ Yes	☐ Constant	☐ Occasional
Throbbing	☐ Yes	☐ Constant	☐ Occasional
Shooting	☐ Yes	☐ Constant	☐ Occasional
Stabbing	☐ Yes	☐ Constant	☐ Occasional
Gnawing	☐ Yes	☐ Constant	☐ Occasional
Sharp	☐ Yes	☐ Constant	☐ Occasional
Tender	☐ Yes	☐ Constant	☐ Occasional
Burning	☐ Yes	☐ Constant	☐ Occasional
Exhausting	☐ Yes	☐ Constant	☐ Occasional
Tiring	☐ Yes	☐ Constant	☐ Occasional
Penetrating	☐ Yes	☐ Constant	☐ Occasional
Nagging	☐ Yes	☐ Constant	☐ Occasional
Numbing	☐ Yes	☐ Constant	☐ Occasional
Miserable	☐ Yes	☐ Constant	☐ Occasional
Unbearable	☐ Yes	☐ Constant	☐ Occasional

Other word(s) to describe your pain: ____

❻ During the past three (3) days, indicate what your pain has interfered with: Check (✓) all that apply

☐ Self care ability ☐ Walking ability ☐ Work ☐ Sleep ☐ General Activity ☐ Mood ☐ Concentration ☐ ______________
Other: ____

❼ What kinds of things make your pain worse? (for example: bending, walking, turning, in the morning, after activity)

____

❽ What kinds of things make your pain feel better? (for example: rest, heat, medicine)

____

Person completing form: ___________________________ ☐ Patient ☐ Other ____________ Date: ____________

The information on this form will be reviewed and discussed with the patient, and the information will be incorporated into the treatment goals and plan of care established in collaboration with the patient.
Refer to individual discipline or service evaluations and care plans.

NRH Rehabilitation Network

PATIENT CONSENTS AND RELEASES

Revised 10.2013

Please read carefully before you sign. Your signature acknowledges understanding of all items set forth herein. If you have questions regarding any sections, please ask the assigned outpatient representative for assistance.

☐ Consent to Medical and Therapeutic Services

I consent to the procedures, which may be performed during the duration of this outpatient treatment, including emergency treatment. I understand that if I fail to carry out the follow-up medical care, I do so at my own risk. I understand that those individuals who attend patients at this facility may include medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care or may provide care as a part of their education. I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether.

☐ Financial Agreement/Guarantee of Payment and Assignment of Benefits

I request that payment of authorized Medicare, Medicaid and/or other benefits be made on my behalf to NRH REHABILITATION NETWORK. I authorize NRH REHABILITATION NETWORK, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. NRH REHABILITATION NETWORK, its agents and employees are hereby released from any and all liability of any nature that may arise from the release of information. I guarantee the payment of the full and entire allowed amount of all bills for services rendered for the patient. Any self-pay amounts not paid within forty-five (45) days of any notice of non-payment shall be subject to progressive collection activities up to and including referral to an independent collection agency. I also understand that all insurance coverage quoted to me and/or responsible parties are estimated and final determination of benefits and coverage lies with my insurance company. I certify that I have disclosed any and all health insurance coverage information and I agree to provide NRH REHABILITATION NETWORK with any changes in my insurance coverage in a timely manner. I understand that as a courtesy and based on the information I provide, NRH REHABILITATION NETWORK will attempt to verify my insurance benefits. I understand that verification is never a guarantee of payment. I am responsible for payment of all co-pays and coinsurance estimates at the time of service and that these estimates may be higher than those for my primary care physician. Once my insurance company has processed claims, if the amount collected at the time of service was not enough to cover my portion, I may be billed in addition to cover my portion. Likewise, if the estimate I paid was more than my portion, I may be entitled to a refund. After 90 days of billing any secondary payer, unpaid coinsurance may become my responsibility.

☐ Managed Care Plan Obligations

I understand that my insurance carrier may require me to have a current and complete written referral from my primary care physician (in some instances the referring physician may be able to provide it). I understand that NRH REHABILITATION NETWORK recommends I check with my carrier directly. If a referral is required and is <u>not</u> presented prior to my treatment being rendered, my insurance may not cover all or a portion of the medical expenses incurred. In this instance, I am responsible for all uncovered charges. It is my responsibility to assist the NRH REHABILITATION NETWORK Outpatient staff in obtaining additional referrals when necessary and appropriate. Should I require additional or more specific information regarding my insurance coverage, I will contact my carrier directly.

☐ Appointment Reminders (Physician services only)

I authorize NRH Rehabilitation Network to send appointment reminders to me via telephone or text message.

Via telephone to: ( ) _______-_________________

Via text to: ( ) _______-_________________ **

**(Standard text message fees from your mobile carrier may apply. This service is only available for physician visits)

Patient/legal guardian signature (seal) ____Date_____________

Home address Telephone Number ____

Witness Signature ____ Date ____________

NRH Rehabilitation Network

Dictation List

Patient Name__________________________________ DOB:____________ MR#______________

Referring Physician	Name:
	Address:
	City, State, Zip:
	Phone #:
	Fax #:
Primary Care Physician	Name:
	Address:
	City, State, Zip:
	Phone #:
	Fax #:
Insurance Company	Name:
	Address:
	City, State, Zip:
	Phone #:
	Fax #:
Case Manager/ Miscellaneous	Name:
	Address:
	City, State, Zip:
	Phone #:
	Fax #:

Date Updated: ____________________________

Date Updated: ____________________________

Date Updated: ____________________________

Date Updated: ____________________________

PATIENT INFORMATION

Welcome to the NRH Rehabilitation Network. Our healthcare professionals provide patients with state-of-the-art rehabilitation technology, therapeutic facilities and medical expertise. All of our facilities feature open exercise as well as private treatment areas. Whether your objectives are to return to work, leisure or sports related activities, we are committed to providing you with excellence in patient care. Your satisfaction is very important to us. Your feedback assists us with improvements. Please take a moment to complete a satisfaction survey and place in the designated box at your treatment location.

PATIENT RIGHTS

As a patient in the NRH Rehabilitation Network, you have the right to:

1. Expect considerate and respectful treatment by our staff and other patients regardless of your race, color, national origin, gender, sexual orientation, religious creed, age, disability, handicap or source of payment for care.

2. The most appropriate medical and clinical services regardless of your race, color, national origin, gender, sexual orientation, religious creed, age, disability, handicap or source of payment for care.

3. Understand your diagnosis and treatment, as well as the possible outcomes, risks and benefits of your care, and be informed of unanticipated outcomes if they should arise.

4. Information about the associated risks, probable results and alternatives before consenting to any procedure or treatment.

5. Information about pain, pain relief measures, and to have your pain evaluated and treated by concerned and committed staff.

6. Be free from all forms of abuse, neglect and harassment.

7. Refuse any drug, procedure, or treatment to the extent permitted by law, and to be informed of medical consequences of your actions.

8. Expect your medical care program and records to be treated confidentially.

9. Obtain a copy of the MedStar Health Notice of Privacy Practices.

10. Access all information in your medical records unless restricted by medical reasons or prohibited by law.

11. Information about our teaching programs if you are asked to cooperate in professional education programs. You may refuse to participate in these programs without bias.

12. Information about any relationship we have with other health care and educational institutions as it concerns your care.

13. An explanation of the need for a transfer to another facility. You must first be accepted by the facility before being transferred.

14. Know your rights and what rules and regulations apply to your conduct as a patient at our network.

15. Information about your continuing health care requirements at the time of discharge.

16. Request an interpreter if you do not speak or understand English, or for sign language.

17. Participate in health care decision-making and have an advance directive honored. Please ensure we have a copy of any Advance Directive on file and discuss with your providers of service. For more information about Advance Directives, contact Outpatient Social Work at 202-877-1664.

18. Participate in discussion of any ethical issues that may arise in your care.

19. Expect privacy and security to be maintained by all of our employees and access to protective services.

PATIENT RESPONSIBILITY

The patient has the responsibility to:

1. Provide complete information about present health complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Cooperate with our personnel working with you and following your recommended treatment plan. Please ask questions if you do not understand any directions given to you.
3. Keep your appointments and notify appropriate staff members if you are unable to do so.
4. Pay bills promptly, obtaining managed care referrals, providing insurance information and asking questions you may have about your bill.
5. Inform your assigned case manager, office coordinator or clinic director as soon as possible if you believe your rights have been violated.

QUESTIONS OR CONCERNS

If you have questions, concerns, comments, or a complaint please contact your assigned administrative operations coordinator or clinic director. They can assist you with questions and concerns about Network policies, facilitating problem resolution and accommodating any special needs. The Network also has a process to address complaints or grievances through the Office of Customer Service. Your administrative operations manager can provide more information on this process.

If you are receiving treatment at our Maryland locations you may choose to contact the Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality, Spring Grove ,Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, or call (410) 402-8000. **If you are receiving treatment at our D.C. locations,** you may choose to contact The District of Columbia Government, Department of Health, Health Regulation Administration, 825 N. Capital St., N.E. Washington, D.C. 20002 or call the complaint desk at: (202) 442-5833. If **you are receiving treatment at our Virginia locations,** you may choose to contact The Virginia Department of Health, Complaint Unit, at 1-800-955-1819.

You may also contact the Joint Commission (JCAHO) by calling: 800 994-6610 or via e-mail at complaint@jcaho.org.

ATTENDANCE POLICY

In order to successfully achieve the goals of treatment established by you and the healthcare professionals, consistent prompt attendance according to your plan of care is essential. Late arrivals may not receive full treatment. As a courtesy to our clinicians and other patients, we appreciate a telephone call at least 24 hours prior to your scheduled appointment. If you need to cancel, please contact the main telephone number of the facility you are attending (listed below).

Our attendance policy is as follows:

If you miss three (3) therapy sessions within one month, even if you call to cancel, you could be discharged from therapy.
If you miss two (2) therapy sessions in a row, or fail to attend 2 evaluation appointments and do not call to cancel, you will be discharged from therapy.
If you miss three (3) treatment sessions at any time during your course of therapy, and do not call to cancel those sessions, you will be discharged from therapy.
Once discharged, your upcoming therapy appointments will be cancelled. In order to be readmitted after discharge, you will need to contact your physician to obtain a new therapy prescription. If you receive a new prescription for therapy, we will reschedule your appointments. If you are discharged more than once for non-compliance with this policy, you will not be rescheduled.

COLLECTION OF PAYMENTS

Co-payments are collected at the time services are rendered at the front desk.

KEY TELEPHONE NUMBERS

❑ Ballston 703-717-6900	❑ Harborview 410-350-8372	❑ Salisbury(Peninsula) 410-546-2702
❑ Bel Air 410-638-9400	❑ Irving St, OCOR 202-877-1566	❑ Pasadena 410-590-8750
❑ Bethesda 301-581-8030	❑ Irving Street 202-877-1760	❑ Stadium Place 410-366-0791
❑ Chevy Chase 301-951-0546	❑ K St, NW 202-466-9719	❑ St Mary's 301-373-2588
❑ CNHC Lutherville 410-823-4263	❑ 19th St, NW 202-721-7680	❑ Waldorf 301-893-2345
❑ Dorsey Hall 410-997-1063	❑ Leisure World 301-438-6280	❑ Wheaton 301-962-7612
❑ Dundalk 410-650-2145	❑ Lutherville Sports 410-512-5820	❑ White Marsh 443-725-2150
❑ Friendship Heights 301-986-4745	❑ Mitchellville 301-390-3076	❑ Wilkins Ave 410-737-8418
❑ Germantown, SWC 301-916-8500	❑ Montrose 301-984-6594	❑ Westminster 410-751-7930
❑ Good Samaritan 443-444-5757	❑ Olney 301-570-3138	❑ Billing Questions 877-558-8549
	❑ Oxon Hill 301-839-0400	❑ CBO 240-965-3500